Aspire Health Plus (HMO-POS) offered by Aspire Health Plan

Annual Notice of Changes for 2023

You are currently enrolled as a member of Aspire Health Plus. Next year, there will be some changes to the plan's costs and benefits. ***Please see page 1 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.aspirehealthplan.org.You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital)
- Review the changes to our drug coverage, including authorization requirements and costs
- Think about how much you will spend on premiums, deductibles, and cost sharing

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2022, you will stay in Aspire Health Plus.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Aspire Health Plus.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at (855) 570-1600 for additional information. (TTY users should call 711). Hours are 8 am to 8 pm PT Monday through Friday from April 1 through September 30, and 8 am to 8 pm PT seven days a week for the period of October 1 through March 31 (except certain holidays).
- This document is also available in alternative formats (i.e., large print, braille and audio CD).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Aspire Health Plus

- Aspire Health Plan is a Medicare Advantage HMO-POS plan sponsor with a Medicare contract. Enrollment in Aspire Health Plan depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Aspire Health Plan. When it says "plan" or "our plan," it means Aspire Health Plus.

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Aspire Health Plus in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$269.00	$269.00
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your in-network covered Part A and Part B services. (See Section 1.2 for details.)	$3,450	$3,000
Doctor office visits	Primary care visits: **In-network:** You pay $0 co-pay. **Out-of-network*:** You pay a 20% co-insurance for each primary care doctor visit. Specialist visits: **In-network:** You pay a $20 co-pay for each specialist visit. **Out-of-network*:** You pay a 20% co-insurance for each specialist visit. *Out-of-network coverage is restricted to Medicare eligible practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.	Primary care visits: **In-network:** You pay $0 co-pay. **Out-of-network*:** You pay a 20% co-insurance for each primary care doctor visit. Specialist visits: **In-network:** You pay a $20 co-pay for each specialist visit. **Out-of-network*:** You pay a 20% co-insurance for each specialist visit. *Out-of-network coverage is restricted to Medicare eligible practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In-network:** Days 1-5: You pay a $250 co-pay per day. Days 6-90: You pay a $0 co-pay per day. **Out-of-network*:** Days 1-90: You pay a 20% co-insurance per stay. *Out-of-network coverage is restricted to Medicare eligible practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.	**In-network:** Days 1-5: You pay a $220 co-pay per day. Days 6-90: You pay a $0 co-pay per day. **Out-of-network*:** Days 1-90: You pay a 20% co-insurance per stay. *Out-of-network coverage is restricted to Medicare eligible practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Co-payment/Co-insurance during the Initial Coverage Stage: Thirty (30) day retail cost-sharing (in network): • **Drug Tier 1:** $0 • **Drug Tier 2:** $10 • **Drug Tier 3:** $42 • **Drug Tier 4:** $90 • **Drug Tier 5:** 33% • **Drug Tier 6:** $11 Ninety (90) day retail cost-sharing (in-network) • **Drug Tier 1:** $0 • **Drug Tier 2:** $30 • **Drug Tier 3:** $126 • **Drug Tier 4:** $270 • **Drug Tier 5:** A long-term supply is not available for drugs in Tier 5 • **Drug Tier 6:** $33	Deductible: $0 Co-payment/Co-insurance during the Initial Coverage Stage: Thirty (30) day retail cost-sharing (in network): • **Drug Tier 1:** $0 • **Drug Tier 2:** $10 • **Drug Tier 3:** $42 • **Drug Tier 4:** $90 • **Drug Tier 5:** 33% • **Drug Tier 6:** $11 Ninety (90) day retail cost-sharing (in-network) • **Drug Tier 1:** $0 • **Drug Tier 2:** $20 • **Drug Tier 3:** $84 • **Drug Tier 4:** $180 • **Drug Tier 5:** A long-term supply is not available for drugs in Tier 5 • **Drug Tier 6:** $22

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 1.5 for details.) *Continued*	Ninety (90) day mail-order cost-sharing (in-network) • **Drug Tier 1:** $0 • **Drug Tier 2:** $20 • **Drug Tier 3:** $84 • **Drug Tier 4:** $180 • **Drug Tier 5:** A long-term supply is not available for drugs in Tier 5 • **Drug Tier 6:** $22	Ninety (90) day mail-order cost-sharing (in-network) • **Drug Tier 1:** $0 • **Drug Tier 2:** $20 • **Drug Tier 3:** $84 • **Drug Tier 4:** $180 • **Drug Tier 5:** A long-term supply is not available for drugs in Tier 5 • **Drug Tier 6:** $22

SECTION 1 Changes to Benefits and Cost for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$269.00	$269.00
Enhanced Benefits – Option A This optional supplemental benefit includes comprehensive dental coverage and an eyewear benefit, and is available for an additional monthly premium.	$44.90 in additional premium per month if you choose to enroll in this optional coverage.	$44.90 in additional premium per month if you choose to enroll in this optional coverage.
Enhanced Benefits – Option B This optional supplemental benefit includes comprehensive dental coverage, an eyewear benefit, a routine hearing exam, a hearing aid benefit, 10 additional one-way rides to in-network appointments, and 14 meals following each inpatient hospital or skilled nursing facility stay or for certain chronic conditions for a temporary period and is available for an additional monthly premium.	$49.90 in additional premium per month if you choose to enroll in this optional coverage.	$49.90 in additional premium per month if you choose to enroll in this optional coverage.

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 5 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for in-network covered Part A and Part B services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,450 Once you have paid $3,450 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.	$3,000 Once you have paid $3,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at www.aspirehealthplan.org. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a *directory*.

There are no changes to our network of providers for next year. There are no changes to our network of pharmacies for next year.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Fitness Benefit	Silver&Fit Healthy Aging and Exercise Program You pay a $0 annual fee.	One Pass - A fitness program to help you stay active physically, mentally, and socially. You pay a $0 annual fee.

Cost	2022 (this year)	2023 (next year)
Inpatient hospital care	Days 1-5: You pay a $250 co-pay per day. Days 6-90: You pay a $0 co-pay per day.	Days 1-5: You pay a $220 co-pay per day. Days 6-90: You pay a $0 co-pay per day.
Inpatient services in a psychiatric hospital	Days 1-5: You pay a $250 co-pay per day. Days 6-90: You pay a $0 co-pay per day.	Days 1-5: You pay a $220 co-pay per day. Days 6-90: You pay a $0 co-pay per day.
Renal Dialysis Services	You pay a $0 co-pay per visit.	You pay a 20% co-insurance per visit.
Skilled Nursing Facility (SNF) Care	Days 1-20: You pay a $20 co-pay per day. Days 21-100: You pay a $50 co-pay per day.	Days 1-20: You pay a $0 co-pay per day. Days 21-100: You pay a $50 co-pay per day.
Out-of-network Point of Service (POS) Benefits **Medicare-covered:** - Renal Dialysis Services - Preventive Services	**Out-of-network*:** You pay a $0 co-pay per visit for renal dialysis services. You pay 20% co-insurance per visit for preventive services.	**Out-of-network*:** You pay a 20% co-insurance per visit for renal dialysis services. You pay a $0 co-pay per visit for preventive services. *Out-of-network coverage is restricted to Medicare eligible practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2022, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages."

The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generic:** You pay $0 per prescription. **Generic:** You pay $10 per prescription. **Preferred Brand:** You pay $42 per prescription. **Non-Preferred Drug:** You pay $90 per prescription. **Specialty:** You pay 33% of the total cost. **Select Insulins:** You pay $11 per prescription. _____ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generic:** You pay $0 per prescription. **Generic:** You pay $10 per prescription. **Preferred Brand:** You pay $42 per prescription. **Non-Preferred Drug:** You pay $90 per prescription. **Specialty:** You pay 33% of the total cost. **Select Insulins:** You pay $11 per prescription. _____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. Insulin products covered on the Select Insulins tier (Tier 6) will be covered at an $11 copay for a one-month supply.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Aspire Health Plus

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Aspire Health Plus plan.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2). As a reminder, Aspire Health Plan offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Aspire Health Plus.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Aspire Health Plus.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2023.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Plus plan for January 1, 2023, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In California, the SHIP is called **California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP)**.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. **California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP)** counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans.

You can call **California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP)** at local: 831-655-1334 or toll free: 800-434-0222. You can learn more about **California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP)** by visiting their website (https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or

- Your State Medicaid Office (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Monterey County ADAP Office located at 340 Church Street, Salinas, CA 93901. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP office at 831-975-5016.

SECTION 6 Questions?

Section 6.1 – Getting Help from Aspire Health Plus

Questions? We're here to help. Please call Member Services at (855) 570-1600. (TTY only, call 711). We are available for phone calls 8 am to 8 pm PT Monday through Friday from April 1 through September 30, and 8 am to 8 pm PT seven days a week for the period of October 1 through March 31 (except certain holidays). Calls to these numbers are free.

Read your 2023 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the 2023 *Evidence of Coverage* for Aspire Health Plus. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.aspirehealthplan.org. You may also call Member Services to ask us to mail you an *Evidence of Coverage.*

Visit our Website

You can also visit our website at www.aspirehealthplan.org. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

You can read the *Medicare & You 2023* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.